**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**
MCALLEN MEDICAL CENTER
3255 W PIONEER PKWY
ARLINGTON TX 76013

**Respondent Name**
ACIG INSURANCE CO

**MFDR Tracking Number**
M4-06-6904-01

**DWC Claim #:**
**Injured Employee**:
**Date of Injury:**
**Employer Name:**
**Insurance Carrier #:**

**Carrier's Austin Representative Box**
47

**MFDR Date Received**

JULY 03, 2006

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Dated April 21, 2006:** "HRA, has been hired by McAllen Medical Center to audit their Workers Compensation claims. We have found in this audit you have not paid the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. The guideline states that items such as implants, prosthetics, blood, pharmacy doses over $250, MRI's, CT's, etc. are to be paid in *addition* the per diem rates. You will need to reprocess those charges as you did not pay for the implants ($36386). Because you did not give a valid denial reason on your EOB for the lack of payment, you will to attach interest pursuant to§413.019 of the Labor Code. "

**Amount in Dispute:** $13,513.50

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** No position statement received along with the DWC60 response

**Response Submitted by:** ACIG Ins

## *SUMMARY OF FINDINGS*

| Disputed Dates | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 01, 2005 through August 13, 2005 | Inpatient Hospital Services | $13,513.50 | $1,369.50 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1 – Workers' compensation state fee schedule adj
- W4 – No additional payment allowed after review

**Issues**

1. Is the requestor entitled to additional reimbursement?

**Findings**

1. "The guideline states that items such as implants, prosthetic, blood, pharmacy doses over $250, MRI's CT's, etc. are to be paid *in addition* the per diem rates." Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   Review of the table of disputed services finds that the items billed under revenue code 0278 are the only services in dispute. 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills and itemized statement finds that the following items were billed under revenue code 0278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

| Charge Code | Itemized Statement Description | Cost Invoice Description | UNITS / Cost Per Unit | Total Cost | Cost + 10% |
|---|---|---|---|---|---|
| 70513130 | Putty Bone | Bone Putty | 2 at $1,185.00 ea | $2,370.00 | $2,607.00 |
| 70580766 | Bone Cancellous Chips | Bone Crushed Cancellous | 1 at $375.00 ea | $375.00 | $412.50 |
| 70575196 | Ortho Implant | No invoice provided | 1 at $0.00 | $0.00 | $0.00 |
| | | | TOTAL ALLOWABLE | $3,019.50 | |

   The division concludes that the total allowable for revenue code 0278 is $3,019.50. The respondent issued payment in the amount of $1,650.00 for revenue code 0278. Based upon the documentation submitted, additional reimbursement in the amount of $1,369.50 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,369.50.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to

additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,369.50 plus applicable accrued interest per 28 Texas Administrative Code §134.803 due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | 10/4/12 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.